Medical Group Management Association
MGMA
Connecticut
A State Affiliate

Statement concerning

House Bill 5579 – An Act Extending the Grace Period for Nonpayment of Premium for Certain Health Plans and Concerning Disclosure by Health Carriers to Health Care Providers of Enrollees' Paid-Up Status

Insurance and Real Estate Committee

March 18, 2014

The Connecticut Medical Group Management Association (CMGMA) submits this statement on behalf of its 415 members because of our strong concerns with House Bill 5579. The stated purpose of the bill is to establish an additional grace period for enrollees in qualified health plans through the health care exchange and to require health carriers to provide notice to health care providers when such enrollees enter such grace periods. We understand that the purpose of the grace period is to provide consumers with medical insurance coverage despite nonpayment of premiums; however we question why it is physicians who must bear the financial risk of such a grace period.

Under the Affordable Care Act (ACA), insurers are required to allow enrollees, a three-month grace period of nonpayment of premiums before discontinuing coverage. Insurers are required to pay claims that arise within the first 30 days of the grace period but are not mandated to pay those that arise in the final 60 days of the grace period. Instead insurers are allowed to "pend" claims during the second and third month, and ultimately deny them. This, of course, means that physicians may see a patient for two months but never get paid for it. If claims are denied after being "pend" physician offices are supposed to then collect the full amount from the patients. As medical group managers, we cannot understand the rationale for putting the financial burden on the physicians, instead of on the insurer. We can tell you that if a patient has not paid their insurance premium, they are not going to pay the physician.

In addition to not having to pay for claims during the last two months of the grace period, according to the bill, insurers are not even obligated to notify physician offices that a patient is within the grace period until the beginning of the second month. Insurers must be required to notify physicians of the grace period during routine insurance eligibility verification requests. As part of a real-time eligibility verification request, it is essential for practices to have accurate, up-to-date information in order to work with patients and plan accordingly for potential financial liabilities associated with non-coverage. Effective Jan. 1, 2013, the operating rules for HIPAA electronic standards for eligibility verification transactions (X12N 270/271) require insurers to provide more robust eligibility information, including patient financial responsibility within 20 seconds (or overnight for batch requests). The goal of this requirement, which stems from Section 1104 of the Affordable Care Act, is to create uniformity with the electronic standard in order to provide clear, accurate and actionable information to providers. It is essential for practices to have this grace period

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eligibility information in the same timely manner. Additionally, if a practice calls the insurer or uses an insurer's online portal to verify eligibility, insurers should be required to provide the grace period information in these instances the same way they would be required to during eligibility verification transactions.

Issuers should be required to provide grace period information by at least day 15 of the 90-day grace period. Should an issuer not provide accurate information related to the grace period during an eligibility verification request, the issuer should be held financially liable for any services furnished during the last 60 days of the grace period for enrollee's whose coverage is ultimately cancelled. Unlike the current environment, where an employer may not provide eligibility information in a timely manner to an insurer, under the exchange program the insurer will have this information at the start of the 90-day grace period. Issuers should be required to share this information with providers as soon as possible. Failure to provide this essential information as part of eligibility verification during the grace period would be unacceptable and represent the purposeful withholding of pertinent eligibility information, contrary to the entire point of eligibility verification requirements under the law.

We realize that with landmark legislation such as the ACA, there are issues that need to be worked out so that the system is fair to all parties. We look forward to working together to find a fair and reasonable solution to this situation in order to protect consumers, issuers and providers.

The Connecticut Medical Group Management Association prides itself in being the trusted resource for Connecticut's health care management professionals. The purpose of the Connecticut Medical Group Management Association is to enhance the performance of health care management professionals to benefit their organizations through education, certification and advocacy.

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